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G 000	INITIAL COMMENTS This visit was a home health federal recertification survey. The survey was partially extended on 1/19/10. Date of survey: 1/12/12 and 1/17-20/12 Facility #: IN0005891 Medicaid Vendor #: 100471080A Surveyor: Janet Brandt, RN, PHNS Number of records reviewed: 16 Number of active records reviewed: 15 Number of closed records reviewed: 1 Census: 782 Quality Review: Joyce Elder, MSN, BSN, RN February 1, 2012	G 000		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure visits were made as ordered on the Plan of Care for 11 of 16 records reviewed with the potential to affect all patients in the agency. (#1, 2, 3, 5, 6, 7, 9, 10, 12, 14, and 15) Findings include:	G 158		2/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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1. Clinical Record #1, start of care 12/29/11, included a plan of care for the certification period 12/29/11-2/26/12 with orders for Home Health Aide (HHA) services 3 times a week for 4 weeks and 2 times a week for 4 weeks. The record failed to evidence any HHA visits were completed during week 1. Two HHA visits were documented week 2 on 1/2/12 and 1/3/12 and week 3 on 1/6/12 and 1/10/12 , not 3 as ordered.

A. The Plan of Care indicates a Physical Therapy (PT) visit was to occur 1 time the first week and 2 times a week for 4 weeks. The record failed to evidence a PT visit occurred week 1, and a PT evaluation was completed visit week 2, not 2 times as ordered.

B. The Plan of Care ordered Occupational Therapy (OT) 1 time the first week to evaluate. No OT visit occurred during week 1; however an OT visit was documented during week 2 on 1/3/12.

C. On 1/21/12 at 2:30 PM EST, Employee A indicated there was no further documentation for the clinical record.

2. Clinical record #2, start of care 11/22/11, included a plan of care for the certification period 11/22-1/20/12 with orders for the skilled nurse (SN) to visit 1 time the first week, 3 times per week for 2 weeks, 2 times per week for 2 weeks, and 1 time per week for 4 weeks. Only 2 SN visits were recorded for week 3 on 12/2 and 12/5. Only 1 SN visit was completed week 5 on 12/20/11, not 2 as ordered. On 1/21/12 at 1:30 PM EST, Employee A indicated there was no

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G 158	Continued From page 2 further documentation for the clinical record. The plan of care identified HHA visits were ordered 3 times per week for 8 weeks. The record failed to evidence any HHA visits for week 1. During weeks 2, 5, 6, and 7, only 2 HHA visits occurred, not 3 as ordered. The record evidenced only 1 visit was made week 3, not 3 as ordered. On 1/20/12 at 12:30 PM EST, Employee A indicated no further documentation was available for the clinical record and visit were not made as ordered on the Plan of Care. 3. Clinical record #3, SOC 1/4/12, included a plan of care for the certification period 1/4/12-3/12/12 with orders for a PT visit 1 time during week 1. The record failed to evidence the PT made a visit during week 1. On 1/20/12 at 11:30 AM EST Employee A indicated there was no further documentation available for the clinical record and visits were not made as ordered on the Plan of Care. 4. Clinical record #5, SOC 11/17/11, included a plan of care for the certification period 11/17/11-1/16/12 with orders for SN visits 4 times a week for 9 weeks. The record evidenced only 1 SN visit weeks 1 and 5, 6 SN visits week 2, 3 SN visits weeks 3, 4, and 9, 2 SN visits week 6, and 7 SN visits week 8. On 1/20/12 at 2:30 PM EST, Employee A indicated there was no further documentation available for the clinical record and visits were not made as ordered on the plan of care. 5. Clinical record #6, SOC 10/07/11, included a plan of care for the certification period	G 158		

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12/06-2/3/12 with orders for the SN to visit 3 times per week for 9 weeks. The record evidenced only 1 SN visit was made week 1, only 2 visits were made weeks 2, 4, and 6. On 1/20/12 at 2:45 PM, Employee A indicated no further documentation was available for the clinical record and visits were not made as ordered on the plan of care.

6 Clinical record #7, SOC 7/11/11, included a plan of care for the certification period 1/7/12-3/6/12 with orders for SN visits 3 times a week for the certification period. The record evidenced 2 SN visits on weeks 1 and 2. On 1/20/12 2:45 PM, the Director of Operations indicated no other documentation was available for record and visits were not made as ordered on the plan of care.

7. Clinical record #9, SOC 7/1/11, included a plan of care for the certification period 12/28/11-2/15/12 with orders for HHA visits 3 times a week for 9 weeks. The record failed to evidence any HHA visits were completed or that the HHA services were discontinued.

The plan of care evidenced the SN was to visit 1 time daily for 60 days. The record failed to evidence a SN visit was completed 1/13/12. On 1/20/12 2:45 PM, Employee A indicated no other documentation was available for the record and the visits were not made as ordered on the plan of care.

8. Clinical record #10, SOC 12/4/11, included a plan of care for the certification period 12/4-1/1/12 with orders for the SN to visit 2 times a week for 4 weeks, then 1 time weekly for 5 weeks. On

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12/9/11 the Plan of Care was revised for skilled nursing to visit 3 times for 1 week, 2 times a week for 4 weeks and 1 time a week for 3 weeks. The record evidenced only 2 SN week 3.

A. The plan of care included orders for PT to visit 1 time week 1. The record failed to evidence the PT made a visit week 1. A PT visit was made on week 2.

B. The plan of care included orders OT to visit 1 time the first week. Pth e record failed to evidence any OT visits had been completed.

C. The plan of care included orders for the HHA was to visit 3 times during week 1. The record evidenced only 1 HHA visit during week 1. On 12/9/11, the POC was revised to indicate the HHA was to visit 4 times a week for 8 weeks. The record evidenced on 2 visits were made week 2 and 3 visits were made weeks 3 and 5. On 1/20/12 at 12:45 PM, Employee A indicated no other documentation available and the visits were not made as ordered on the plan of correction.

9. Clinical record #12, SOC 12/29/11, included a plan of care for the certification period 12/29/11-2/26/12 with orders for OT to visit 1 time week 1. The record failed to e evidence the OT made a visit. On 1/19/12 4:45 PM, employee C indicated no other documentation was available.

10. Clinical record #14, start of care (SOC) 12/22/11, included a Plan of Care (POC) for the certification period 12/22/11-2/19/12 with orders for OT to complete an OT evaluation during week 1. The record failed to evidence an OT evaluation had been completed. On 1/20/12 2:30

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G 158	Continued From page 5 PM EST, Employee A indicated the OT evaluation was not completed as ordered. 10. Clinical record #15, SOC 1/03/12, included a plan of care for the certification period 1/3/12-3/2/12 with orders for the SN to visit 1 time a week for 9 weeks. The record failed to evidence the SN made a visit week 1. The plan of care identified the HHA was to visit 2 times a week for 9 weeks. The record failed to evidence any HHA visits were made week 1. 11. On 1/20/12 at 2:30 PM EST, Employee A indicated the clinicians may have failed to follow the Plan of Care due to the staff was "adjusting to a different clinical week (Friday to Thursday) and visit frequencies may not have been per the Plan of Care." .	G 158		
G 186	484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by: Based on interview and review of clinical records and policy, the agency failed to ensure the Occupational Therapist (OT) performed an OT evaluation as ordered on the Plan of Care for 3 of 9 records reviewed of patients receiving OT services with the potential to affect all patients receiving OT from the agency. (#, 10, 12, and14)	G 186		2/14/12

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G 186	Continued From page 6 Findings include: 1. Clinical record #10, start of care 12/4/11, included a plan of care for the certification period 12/4-1/1/12 with orders for the OT to visit 1 time the first week. The record failed to evidence any OT visits had been completed. 2. Clinical record #12, start of care 12/29/11, included a plan of care for teh certification period 12/29/11-2/26/12 with orders for OT to visit 1 time week 1. The record failed to e vidence the OT made a visit. On 1/19/12 4:45 PM, emplyoyee C indicated no other documentation was available. 3. Clinical record #14, start of care (SOC) 12/22/11, included a plan of care for the certification period 12/22/11-2/19/12 with orders for OT to complete an OT evaluation during week 1. The record failed to evidence an OT evaluation had been completed. On 1/20/12 2:30 PM EST, Employee A indicated the OT evaluation was not completed as ordered. 4. Policy #33.11 titled "Occupational Therapy Services", dated 5/4/89, states, "Duties of the therapist include: Develops and implements an individualized care plan in accordance with the physician plan of treatment within five (5) days of the initiation of service."	G 186		
G 190	484.32(a) SUPERVISION OF PHYSICAL & OCCUPATIONAL Services furnished by a qualified physical therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A	G 190		2/14/12

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G 190	Continued From page 7 physical therapy assistant or occupational therapy assistant performs services planned, delegated, and supervised by the therapist. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the physical therapist and occupational therapist cosigned the occupational therapy assistant and physical therapy assistant notes in 2 of 9 clinical records reviewed of patients receiving therapy services with the potential to affect all patients receiving therapy services from the agency. (#1 and 14) Findings include: 1. Agency policy #33.11 "Occupational Therapy Services", dated 5/4/89, under "Policy & Purpose Statement," states, #3: "The duties of the therapist include . . . evaluates care rendered by Occupational Therapist Assistant [COTA]. Cosigns all clinical documentation." 2. Agency policy #33.09 "Physical Therapy Services" dated 5/4/89, under "Policy & Purpose Statement," states, #3: "The duties of the therapist include . . . evaluates care rendered by Physical Therapist Assistant [PTA]. Cosigns all clinical documentation." 3. Clinical record #1, start of care (SOC) 12/29/11, included a Plan of Care (POC) for the certification period 12/29/11-2/26/12 with orders for Physical Therapy (PT) and Occupational Therapy (OT) services. The OTA made a visit 1/10/12 and the COTA's name was listed as the "author" and the note was completed on 1/11/12.	G 190		

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A line titled "OT Signature" evidenced the words "OT Signature" printed in the space. The bottom of page 2 (page 2 of 2) evidenced a message that stated, "DOCUMENT SIGNED ELECTRONICALLY 1/11/12 12:22:00 PM." The visit note failed to evidence a cosigned signature electronically or hand written of an OT.

A. An initial evaluation visit by PT was documented on 12/30/11. On 1/10/12 a visit note was completed by a PTA. The visit note identified the PTA as the author of the note. A message across the bottom of page 2 (page 2 of 2) states, "Document signed electronically 01/10/12 12:42:00 PM." A second PTA visit note was completed on 1/12/12 and the message across the bottom of page 2 (page 2 of 2) states, "Document signed electronically 01/12/2012 3:46:00 PM." No PT co-signature was found in the visit notes.

B. Employee A indicated, on 1/20/12 at 3:00 PM EST, PTA and COTA visit notes should have co-signature by a therapist.

4. Clinical record #14, SOC 12/22/11, included a POC for the certification period 12/22/11-2/19/12 with orders for PT services. A PTA visit note dated 12/22/11 on page 2 (page 2 of 2) evidenced the message, "Document signed electronically 12/27/2011 4:17:00 PM." No PT co-signature was found in the visit notes.

On 1/20/12 at 3:00 PM, Employee A indicated no other documentation was available for the record.

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G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on interview and review of records and policy and procedure, the agency failed to ensure a drug review was done and/or updated as needed for 2 of 16 records reviewed with the potential to affect all patients in the agency. (#2 and 4) Findings include: 1. Clinical record #1, Start of Care (SOC) 12/29/11, evidenced an initial comprehensive assessment completed 12/29/11. The record failed to evidence a drug regimen review had been completed. A. On 1/19/12 at 3:00 PM EST, Employee A indicated the drug regimen review is to be completed with the initial comprehensive assessment and is supposed to be in the patient's home where it is reviewed with patient on admission and with updates. The drug regimen review document can be mailed to the patient if completed after the visit; the clinician records the date the document was mailed to patient in the chart. The facility was unable to provide documentation a drug regimen review	G 337		2/14/12

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had been completed or mailed to the patient as of 1/20/12 at 3:30 PM per Employee A.

B. On 1/12/11 at 3:30 PM EST, during a home visit, the agency documents in the patient's home were reviewed. The folder evidenced a drug regimen review document that was blank in the patient file folder. Patient indicated all agency documents were kept in the folder and there were no other documents from the agency in the home.

2. Review of clinical record #4, start of care (SOC)12/04/11, evidenced a physician order dated 12/22/11 to "Restart Coumadin, Take 2 mg [milligram] on Wed [Wednesday] and Sat [Saturday] and 1 mg the rest of the wk [week]. Repeat INR [blood test] 12/27/11." Across the middle of the page is a hand written note that states, "This is an incorrect order. Correct order is: Mon [Monday], Wed, Sat -2 mg. T [Tuesday], Th [Thursday], F [Friday], Sun [Sunday] -1 mg." The record failed to evidence the drug review had been updated for this medication.

On 1/20/12 at 3:25 PM, Employee C presented a "Customer Medication Profile" dated 12/04/11 and an "Admission Note Report" dated 12/21/11 indicating a medication profile was completed and a 12/23/11 notation that the medication profile was mailed to the patient's home. There was no documentation to evidence the 12/4/11 medication profile was updated or that the patient received an updated medication list. Employee C indicated, on 1/20/12 at 3:25 PM, no other documentation was available.

5. Policy #33.48 titled "Comprehensive Drug

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G 337	Continued From page 11 Regimen Review, Adverse Drug Reactions and Medication Errors Response", 10/10/89, states, "The clinician will complete a comprehensive drug regimen review at the start of care, resumption of care, recertification, discharge, with any medication change and as client needs dictate. Communicate any potential or actual adverse interaction to the physician. Document all interactions and follow up in the clinical record."	G 337		